Print Form

NY STATE CLIENT SEMI-ANNUAL REPORT

Marking Instructions: Please type or use blue or black ink pen.
Completely fill in one circle.
Print legible numbers and block letters, no script

COMPLETE ALL SECTIONS before submitting or form will be returned.

I Reporting Information

Year: 2012 (Amendment)

Fill in circle if amendment ○

Report Period: ○ January/June ● July/December

Type of Lobbying: ○ Nonprocurement ○ Procurement ○ Both

Client Filing Fee Check Number:

FOR OFFICE USE ONLY Amendment
Cjm
I. NonProc.
Amended to add S of F info.
RECEIVED FEB 13 2013

II Client Information

Name: Coalition of NYS Public Health Plans (FKA Coalition of NYS Prepaid Health Services Plans)

Permanent Business Address: 7 Times Square, 23rd Floor

City: New York State: NY ZIP code: 10036

Business Phone: (212) 790-4582 Fax Number:

Third Party Beneficiary (see instructions):

III Lobbyist(s) Information & Compensation (Current Period Only)

Any individual or organization that has lobbied on behalf of the client must be reported below, regardless of whether the threshold was exceeded by that individual or organization.

A Type of Lobbyist: ● Retained ○ Employed ○ Designated

Level of Gov't: ● State Lobbying ○ Local Lobbying ○ Both

Name: Hinman Howard & Kattell LLP Phone Number: (518) 431-6700

Address: 30 S. Pearl St. 12th FLOOR

City: Albany State: NY ZIP code: 12207

Compensation for current period: $ 120,000 .00

B Type of Lobbyist: ○ Retained ○ Employed ○ Designated

Level of Gov't: ○ State Lobbying ○ Local Lobbying ○ Both

Name: Phone Number:

Address:

City: State: ZIP code:

Compensation for current period: $ .00

C Type of Lobbyist: ○ Retained ○ Employed ○ Designated

Level of Gov't: ○ State Lobbying ○ Local Lobbying ○ Both

Name: Phone Number:

Address:

City: State: ZIP code:

Compensation for current period: $ .00

○ Continued on attached pages

D **TOTAL COMPENSATION** of ALL lobbyists for current period.....(A+B+C+addendum sheets): $ 120,000 .00

IV Other Expenses (Current Semi-Annual Period Only)

A Report in the aggregate all expenses less than or equal to $75: $ 50 .00

B Report in the aggregate all expenses for salaries of non-lobbying employees: $ 0 .00

C Itemize each expense exceeding $75:

PAID TO: DATE: / / ○ Ad ○ Social Event

PURPOSE: AMOUNT: $ .00 ○ *Addendum attached

○ PROCUREMENT ○ NONPROCUREMENT

PAID TO: Marath Phelps Phillips DATE: 8/31/12 ○ Ad ○ Social Event

PURPOSE: Messenger SVC AMOUNT: $ 115 .00 ○ *Addendum attached

○ PROCUREMENT ● NONPROCUREMENT

○ Continued on attached pages

* If any expense listed above exceeds $75 for an individual, you must attach the addendum page listing the expense, dollar amount attributable to the individual and the name, title and employer of the individual.

D Total expenses for current period: $ 165 .00 (if applicable, include all expenses from attached pages in total)

V Source of Funding Disclosure

Instructions: **In the event only one person or entity is listed as the Single Source for a Contribution(s), use Section A. In the event multiple persons or entities have been aggregated as a Single Source for a Contribution(s), use Section B.**

A **Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received. If more than five Contributions from the Single Source have been received, use section V(C) of the Addendum for the additional Contributions.**

Contribution(s) from Single Source #1

Single Source Entity's Name: The Monroe Plan

or
Single Source Person's Last Name: First Name:

Address: 1120 Pittsford-Victor Rd

City: Pittsford State: NY ZIP code: 14534

Phone: (585) 256-8404

Date Contribution Received: 7/1/12 Amount of Contribution: $ 15,257 .00

Date Contribution Received: / / Amount of Contribution: $ .00

Date Contribution Received: / / Amount of Contribution: $ .00

Date Contribution Received: / / Amount of Contribution: $ .00

Date Contribution Received: / / Amount of Contribution: $ .00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contribution(s) Single Source #2

Single Source Entity's Name: Total Care

or
Single Source Person's Last Name: First Name:

Address: 819 S. Salina st.

City: Syracuse State: NY ZIP code: 13202

Phone: (315) 476-7921

Date Contribution Received: 7/1/12 Amount of Contribution: $ 12,199 .00

Date Contribution Received: / / Amount of Contribution: $ .00

Date Contribution Received: / / Amount of Contribution: $ .00

Date Contribution Received: / / Amount of Contribution: $ .00

Date Contribution Received: / / Amount of Contribution: $ .00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Check here if there are Contribution(s) from Single Source(s) other than those listed above. Use Section V(A) of the Addendum to list all such Contributions: ○

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A **Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.**

Contributions from Single Source #3

Single Source Entity's Name: VNSNY Choice Health plans

or

Single Source Person's Last Name: First Name:

Address: 1250 Broadway, 11th Floor

City: New York State: NY ZIP code: 10001

Phone: (212) 609-5631

Date Contribution Received: 7/1/12	Amount of Contribution: $	4,748	.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contributions from Single Source # ____

Single Source Entity's Name: AmidaCare

or

Single Source Person's Last Name: First Name:

Address: 248 W. 35th St. 7th FLOOR

City: New York State: N.Y. ZIP code: 10001

Phone: (646) 786-1804

Date Contribution Received: 7/1/12	Amount of Contribution: $	11,370	.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contributions from Single Source #____

Single Source Entity's Name: Affinity Health ~~Plan~~ Plan

or

Single Source Person's Last Name: First Name:

Address: 2500 Halsey St.

City: Bronx State: NY ZIP code: 10461

Phone: (718) 794-7691

Date Contribution Received: 7/1/12	Amount of Contribution: $	16,667	.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00
Date Contribution Received: / /	Amount of Contribution: $		.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed please make a copy of this sheet.

V Source of Funding Disclosure

A **Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.**

Contributions from Single Source #3

Single Source Entity's Name: Fidelis Care New York
or
Single Source Person's Last Name: First Name:

Address: 45-25 Queens Blvd 8th Fl

City: Rego Park State: NY ZIP code: 11374

Phone: (718) 343-6101

Date Contribution Received:	7 / 1 / 12	Amount of Contribution: $	25,811.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contributions from Single Source # ___

Single Source Entity's Name: Health First
or
Single Source Person's Last Name: First Name:

Address: 100 Church St.

City: New York State: NY ZIP code: 10007

Phone: (212) 801-1500

Date Contribution Received:	7 / 1 / 12	Amount of Contribution: $	21,505.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contributions from Single Source #_____

Single Source Entity's Name: Hudson Health Plan
or
Single Source Person's Last Name: First Name:

Address: 303 S. Broadway Suite 321

City: Tarrytown State: NY ZIP code: 10591

Phone: (914) 631-1611

Date Contribution Received:	7 / 1 / 12	Amount of Contribution: $	13,561.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A **Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.**

Contributions from Single Source #3

Single Source Entity's Name: Metroplus Health Plan
or
Single Source Person's Last Name: First Name:

Address: 160 Water St. 3rd Floor

City: New York State: NY ZIP code: 10038

Phone: (212) 908-8682

Date Contribution Received:	7 / 1 / 12	Amount of Contribution: $	19,793.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contributions from Single Source # ____

Single Source Entity's Name: Neighborhood Health Providers
or
Single Source Person's Last Name: First Name:

Address: 521 Fifth Ave 3rd FL

City: New York State: NY ZIP code: 10175

Phone: (212) 808-4775

Date Contribution Received:	7 / 1 / 12	Amount of Contribution: $	15,547.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

Contributions from Single Source #_____

Single Source Entity's Name:
or
Single Source Person's Last Name: First Name:

Address:

City: State: ZIP code:

Phone:

Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00
Date Contribution Received:	/ /	Amount of Contribution: $	.00

Check here if using section V(C) of the Addendum for additional Contributions: ○

VI Subjects lobbied:

Issues affecting the operations & finances of prepaid health svc. plans including Medicaid Managed Care, Child Health plus and Family Health Plus

○ Continued on attached pages

VII Person, State Agency, Municipality or Legislative Body lobbied:

Governors office, NYS Assembly, NYS Senate, Dept. of Health NYS Insurance Dept.

○ Continued on attached pages

VII Bill, Rule, Regulation, Rate Number or brief description relative to the introduction or intended introduction of legislation or a resolution on which you lobbied:

n/a

○ Continued on attached pages

VIII Title and Identifying Numbers of procurement contracts/documents lobbied:

n/a

○ Continued on attached pages

IX Number or Subject Matter of Executive Order of Governor/Municipality lobbied:

n/a

○ Continued on attached pages

X Subject Matter of and Tribes involved in tribal-state compacts, etc lobbied:

n/a

○ Continued on attached pages

XI Declaration

This Declaration must be signed by the Chief Administrative Officer. (If the Chief Administrative Officer, for any reason, does not sign, he/she must duly designate another person to sign this Declaration.) **(See instructions.)**

I declare under penalty of perjury that the information contained in this report is true, correct, and complete to the best of my knowledge and belief.

X SIGNATURE: Pat Wang **DATE:** 2/7/13

PRINT NAME: LAST Wang **FIRST** Pat

TITLE: Coalition Chairperson

Mark One: ● Chief Administrative Officer ○ Designee(Attach Letter)

The following MUST be attached to this report at the time of submission:

--You must attach a **$50 dollar filing fee** to each semi-annual report. (No fee is required for amendments to the original)
--If applicable, a designation letter if you have marked designee in section XI.
--If applicable, continuation sheets for sections III,IV,V,VI,VII,VIII,IX and X.

PLEASE NOTE **You may be assessed up to $25 for each day this report is late.**